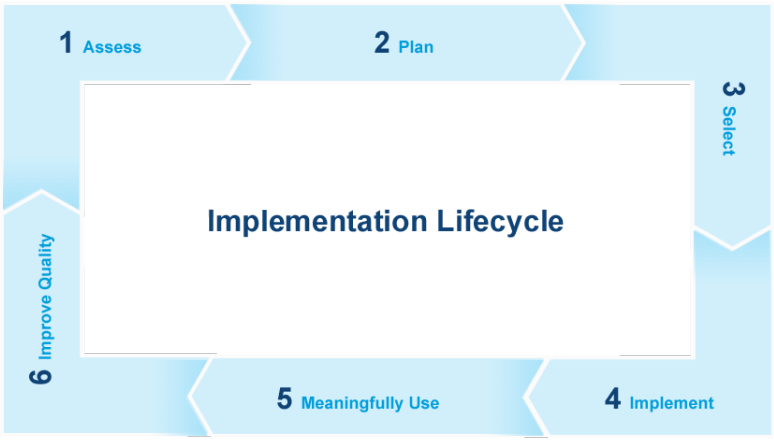
The Office of the National Coordinator for Health Information Technology

Clinical Decision Support/Quality Improvement Worksheet - Inpatient

Template (Essential Version)

February 28, 2014 • Version 1.0



DESCRIPTION & INSTRUCTIONS

This tool is intended to aid providers and health IT implementers in documenting and analyzing current approaches to specific quality improvement targets and plan enhancements.

Quality improvement (QI) efforts should be based on evidence-based guidelines related to the target. The EHR vendor, REC, specialty society, guidelines.gov and other resources can help identify these guidelines and ensure that order sets, documentation templates, flowsheets, and other QI tools support implementation.

Step 1: Document the target and think about pertinent information flows and workflows.

Step 2: Think about major activities that influence performance on the target at each care flow step. Document these on the subsequent pages. After listing these activities, think about and document potential enhancements.

Step 3: Review all entries and summarize them in the table below the flowchart on the next page.

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LIST OF EXHIBITS

The Office of the National Coordinator for Health Information Technology

1 Inpatient CDS/QI Worksheet (Essential Version)

Target	
Current Performance on Target	

Reset Fields (all pages)

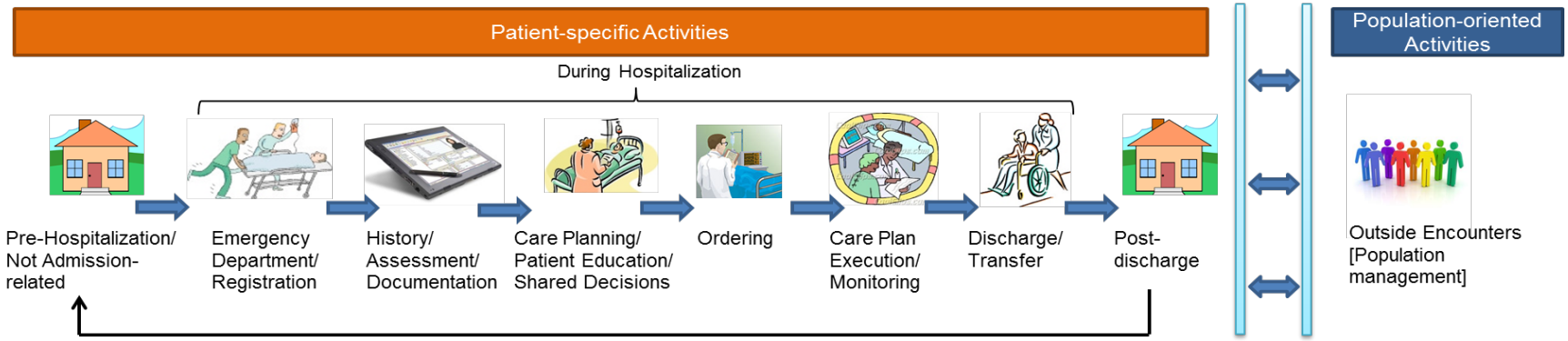

Exhibit 1 CDS/QI Approach Summary

	Pre-Hospitalization/ Not Admission-related	Emergency Department/ Registration	History/ Assessment/ Documentation	Care Planning/ Patient Education/ Shared Decisions	Ordering	Care Plan Execution/ Monitoring	Discharge/ Transfer	Post-Discharge	Outside Encounters
Current Information Flow									
Enhancements									

1.1 ACTIVITIES THAT OCCUR WITH SPECIFIC PATIENTS

Note: population management activities, e.g. Registry use, belong in activities that relate to population management.

1.1.1 These activities occur when the patient is not in the hospital (see below for post-discharge)

 **Pre-Hospitalization/ Not Admission- related**	**Description:** When patient is at home - either with or without a new hospitalization planned.
Current Information flow	•
Potential Enhancements	•

 **Emergency Department/Registration**	**Description:** When patient is physically in Emergency Department and/or being registered for inpatient admission.
Current Information flow	•
Potential Enhancements	•

 **History/ Assessment/ Documentation**	**Description:** Clinician data gathering from and about patient, and formulating assessments and diagnoses based on this information.
Current Information flow	•
Potential Enhancements	•

 **Care Planning/ Patient Education/ Shared Decisions**	**Description:** Reviewing assessment with patient/family and jointly forming care plans, including educating patient/family about diagnosis and treatment.
Current Information flow	•
Potential Enhancements	•

 **Ordering**	**Description:** Provider orders for tests, medications, procedures, etc
Current Information flow	•
Potential Enhancements	•

 **Care Plan Execution/ Monitoring**	**Description:** Carrying out and monitoring the treatment plan including: pharmacy medication verification and dispensing and nursing administration; respiratory and other therapy administration and procedures; inpatient consultations; and monitoring patient status and test results.
Current Information flow	•
Potential Enhancements	•

 **Discharge/ Transfer**	**Description:** Discharging patient to home or transfer to another inpatient unit or facility.
Current Information flow	•
Potential Enhancements	•

1.1.2 These activities occur after a patient leaves the hospital

 **Post-Discharge**	**Description:** Patient and hospital activities that occur after hospital discharge.
Current Information flow	•
Potential Enhancements	•

1.2 ACTIVITIES THAT RELATE TO POPULATION MANAGEMENT

 **Outside Encounters**	**Description**: When patient is at home - either with or without a new hospitalization planned.
Current Information flow	•
Potential Enhancements	•